ALTAMONTE MEDICAL ASSOCIATES, P.A.

1864 N. Alafaya Trail, Suite B
Orlando, FL 32826
Phone: 407-384-1414
Fax: 407-384-1314

631 Palm Springs Drive, Suite 117
Altamonte Springs, FL 32701
Phone: 407-339-5600
Fax: 407-339-5602

PATIENT INFORMATION FORM

DATE:_____

NEW PATIENT CHANGE OF INFORMATION

PERSONAL DATA

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ S.S. #_____

_____ HOME PHONE:_____

_____ CELL PHONE:_____

GENDER: (circle one) FEMALE MALE EMAIL:_____

EMPLOYER NAME:_____ PHONE:_____

ADDRESS:_____

INSURANCE NAME:_____

PRIMARY CLAIMS ADDRESS:_____
(P.O.BOX/STREET) (CITY/STATE) (ZIP)

TELEPHONE #_____ POLICY #_____ GROUP#_____

SECONDARY CLAIMS ADDRESS:_____
(P.O.BOX/STREET) (CITY/STATE) (ZIP)

TELEPHONE #_____ POLICY #_____ GROUP#_____

EMERGENCY CONTACT NAME:_____

RELATIONSHIP_____ PHONE #_____

I authorize Altamonte Medical Associates, P.A. to release any medical information necessary to process claims, coordinate care, and for quality management and/or utilization activities.

_____
(signature) (date)

I authorize payment of medical benefits to Altamonte Medical Associates, P.A. for services rendered.

_____
(signature) (date)

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PATIENT DATA SHEET

NAME:_____ DATE OF BIRTH:_____ SEX:_____ Race:_____

MARITAL STATUS: Single Married Divorced Widowed Separated

OF CHILDREN_____ # OF PERSONS IN HOUSEHOLD_____ EDUCATION/GRADE_____

PATIENT HISTORY

LAST MEDICAL EXAM_____ LAST EYE EXAM_____

PRESENT MEDICAL CONDITIONS:

____ High Blood Pressure ____ Lung Disease ____ Other
____ Diabetes ____ Cancer of _____ _____
____ Heart Disease ____ Depression _____

List all past Major illnesses/ Hospitalizations/Surgeries — Year

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Immunizations: — Date of injection

Tetanus_____ _____
Pneumovax_____ _____
Hepatitis B_____ _____
_____ _____

List all Drug and Food Allergies and type of reaction

_____ _____
_____ _____
_____ _____
_____ _____

List all current medications, vitamins, over the counter drugs, birth control, including name, strength, and dosing frequency.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

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FAMILY HISTORY

List any significant family medical history (e.g., diabetes, high blood pressure, cancer, etc.)

FAMILY MEMBER	MEDICAL HISTORY
FATHER	
MOTHER	
BROTHER(S)	
SISTER(S)	
CHILDREN	

CURRENT LIFESTYLE

CURRENT OCCUPATION:_____

NAME ANY CHEMICAL OR OTHER HAZARDS ON THE JOB:_____

1. Do you drink alcohol? Yes No How much?_____
2. Do you feel you have been exposed to AIDS? Yes No
3. Do you smoke or chew tobacco? Yes No How much?_____
4. Do you ever use illicit drugs? Yes No How much?_____
5. Do you have any sexual concerns? Yes No

NAME ANY HOBBIES AND/OR RECREATIONAL ACTIVITIES:_____

PATIENT SIGNATURE:_____ DATE:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Altamonte Medical Associates, P.A. Notice of Privacy Practices provides information about how we use and disclose protected health information about you. You have the right to review our notice before signing this form. We reserve the right to change the privacy practices outlined in the notice. You may obtain a copy by contacting us.

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment or for health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and operations as described in our notice. You have the right to revoke this consent, in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I have read the Altamonte Medical Associates, P.A. Notice of Privacy Practices.

NAME:_____
(please print)

SIGNATURE:_____ DATE:_____

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DATE:_____

NAME:_____

SS#:_____

I, _____, give my permission and authorization to Altamonte Medical Associates and staff to disclose any confidential and privileged information with the following entities, (hospital, doctor's offices, eye clinic, dental offices, pharmacy, and insurance agencies) which may be treating me or in my personal health car to discuss and fully disclose any and all information about my medical condition or treatment. Also any diagnosis, prognosis, treatment, care bills, insurance issues can be discussed with the following people:

_____ Relation _____

_____ Relation _____

_____ Relation _____

This authorization is to remain in effect until revoked **IN WRITING** by me.

PATIENT SIGNATURE:_____ DATE:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date of Birth:_____ Social Security Number:_____

I, _____, hereby authorize Altamonte Medical Associates, P.A.
(Name of patients)

▢ Release to ▢ Obtain from ▢ Discuss with

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

I authorize the release of my entire medical record. Any exceptions are noted as follows:

_____

Unless otherwise indicated, my authorization includes the release of the following (please strike through those you wish to exclude, if any):

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- My diagnosis and/or treatment regarding mental health issues
- HIV antibody test results and/or AIDS diagnosis and treatment
- Genetic test results and/or related treatment

You are authorized to accept a photocopy of this authorization in lieu of the original.

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either 180 days after the date of signature or automatically when the records requested on this form have been mailed to the requestor.

PROHIBITION ON REDISCLOSURE: The confidentiality of the information disclosed pursuant to this authorization is protected by state and federal law. Any further disclosure is strictly prohibited.

Date:_____Signed:_____ Signed:_____
(Patient) (Witness)

*If the patient is unable to give consent because of physical/mental condition or age, complete the following:
Patient is a minor _____ years of age or is unable to give consent because_____.

_____ _____ _____
(Parent/Guardian/POA) Relationship Date